# SECTION 7
# UB-92 CLAIM FILING INSTRUCTIONS
# OUTPATIENT HOSPITAL

**The following instructions pertain to outpatient hospital claims, which are being filed to Medicaid on a paper UB-92 claim form. The requirements for filing an electronic version of the UB-92 claim form for outpatient services are slightly different. If filing claims electronically via the Infocrossing Internet service, www.emomed.com, refer to the help link at the bottom of the electronic UB-92 claim form. If filing electronically using the 837 Institutional Claim, refer to the Implementation Guide for information.**

The UB-92 paper claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims for hospital outpatient care are to be mailed to:

Infocrossing Healthcare Systems, Inc.
P.O. Box 5200
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

**NOTE:** An asterisk (*****) beside field numbers indicates required fields on all outpatient UB-92 claim forms. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (******) beside the field number indicate a field is required in specific situations.

| Field number and name | | Instructions for completion |
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| 1.* | Unlabeled Field | Enter the provider name and address exactly as it appears on the provider label. The 9-digit provider number must either be entered in this field or in field 51. For convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all required information. When affixing the label, do **not** cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form. |
| 2. | Unlabeled Field | Leave blank. |
| 3. | Patient Control Number | Enter the patient's account number assigned by the hospital. |

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| 4.* | Type of Bill | For an outpatient claim, the only allowed type of bill is “131”. |
| 5. | Federal Tax Number | Leave blank. |
| 6. | Statement Covers Period (from and through dates) | Leave blank. |
| 7. | Covered Days | Leave blank. |
| 8. | Non-covered Days | Leave blank. |
| 9. | Coinsurance Days | Leave blank. |
| 10. | Lifetime Reserve Days | Leave blank. |
| 11. | Unlabeled Field | Leave blank. |
| 12.* | Patient Name | Enter the patient’s name in the following format: last name and first name as shown on the Medicaid ID card. |
| 13. | Patient Address | Leave blank. |
| 14. | Patient Birth Date | Leave blank. |
| 15. | Patient Sex | Leave blank. |
| 16. | Patient Marital Status | Leave blank. |
| 17. | Admission Date | Leave blank. |
| 18. | Admission Hour | Leave blank. |
| 19. | Type of Admission | Leave blank unless this claim is for an emergency room service. If so, enter Admission Type 1. Condition Code AJ also must be listed in field 24 to exempt the patient from the $2.00 cost sharing amount for the service. |
| 20. | SRC (Source of Admission) | Leave blank. |
| 21. | Discharge Hour | Leave blank. |
| 22. | Patient Status | Leave blank. |

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| 23. | Medical/Health Record Number | Enter the number that identifies the patient's medical record within the facility. |
| 24.**- 30.** | Condition Codes | Enter the applicable two-character condition code. The values are:<br><br>A1 - EPSDT/HCY. If this service is the result of an HCY referral or is an HCY related visit, enter this condition code.<br>A4 - Family Planning. If family planning services occurred, during this visit, enter this condition code.<br>AJ - Payer Responsible for Co-payment. If this hospital visit is the result of an emergency or therapy services are provided, then condition code must be entered to exempt the patient from the $2.00 cost sharing amount. |
| 31. | Unlabeled Field | Leave blank. |
| 32.** - 35.** | Occurrence Codes | If one or more of the following occurrence codes apply, enter the appropriate code(s) on the claim:<br><br>01 - Auto accident<br>02 - No fault insurance<br>03 - Accident/Tort Liability<br>04 - Accident/Employment Related<br>05 - Accident/No medical or liability coverage<br>06 - Crime Victim |
| 36. | Occurrence Span | Leave blank. |
| 37.** | Internal Control Number (Medicaid Resubmission) | For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim indicating the claim was initially submitted within the 12-month timely filing limit. |
| 38. | Unlabeled Field | Leave blank. |
| 39-41. | Value Codes and Amounts | Leave blank. |

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| 42.** | Revenue Code | If billing for a facility charge, an observation room charge, cardiac rehabilitation, supplies and/or on-site medications, enter only the appropriate 4-digit revenue code(s) for the hospital's outpatient facility charge(s).<br><br>See Section 8 of this book for a list of valid outpatient hospital facility revenue codes. |
| 43. | Description | Leave blank. |
| 44.** | HCPCS/Rates | Enter the CPT or HCPCS procedure code(s) and any applicable modifier, if any, for services **other** than outpatient facility charges listed in field 42. |
| 45.* | Service Date | Enter the date of service on each line billed in MMDDYY numeric format |
| 46.* | Service Units | Enter the number of units for each revenue or procedure code listed.<br><br>NOTE: Facility codes 0450, 0459, 0490, and 0510 should always be billed with a unit of "1". The outpatient observation code, 0762, should be billed with the appropriate unit quantity of "1", "2", "3" or "4". |
| 47.* | Total Charges | Enter the total charge for each line item. After all charge(s) are listed, skip one line and state the total for all charges for this claim to correspond to revenue code 0001. |
| 48. | Non-covered Charges | Leave blank. |
| 49. | Unlabeled Field | Leave blank. |
| 50.* | Payer | Indicate if the patient has a secondary payer by listing the name of the payer on the first line. The primary payer is always listed first; e.g., if the patient has insurance, the insurance plan is the primary payer and "Medicaid" is listed last. |
| 51.** | Provider Number | If the Medicaid provider number was **not** entered in field 1, it must be shown here. |
| 52. | Release of Information | Leave blank. |
| 53. | Assignment of Benefits | Leave blank. |

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| 54.** | Prior Payments | Enter the amount received for each payer(s). Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field. This field is required if other payer information was indicated in field 50. Payments **must** correspond with the appropriate payer entered in field 50. [See Note (1)] |
| 55. | Estimated Amount Due | Leave blank. |
| 56. | Unlabeled Field | Leave blank. |
| 57. | Unlabeled Field | Leave blank. |
| 58.** | Insured's Name | Complete if the insured's name is different from the patient's name. [See Note (1)] |
| 59. | Patient's Relationship to Insured | Leave blank. |
| 60.* | Certificate/SSN Number/ Health Insurance Claim/ Identification Number | Enter the patient's eight-digit Medicaid number as shown on the Medicaid ID card. If insurance was indicated in field 50, enter the insurance number to correspond with the order shown in field 50. |
| 61.** | Group Name | If insurance is shown in field 50, state the name of the group or plan through which the insurance is provided to the insured. [See Note (1)] |
| 62.** | Insurance Group Number | If insurance is shown in field 50, state the number assigned by the insurance company to identify the group under which the individual is covered. [See Note (1)] |
| 63. | Treatment Authorization Code | Leave blank. |
| 64. | Employment Status Code | Leave blank. |
| 65. | Employer Name | Leave blank. |
| 66. | Employer Location | Leave blank. |
| 67.* | Principal Diagnosis Code | Enter the complete ICD 9-CM diagnosis code. |

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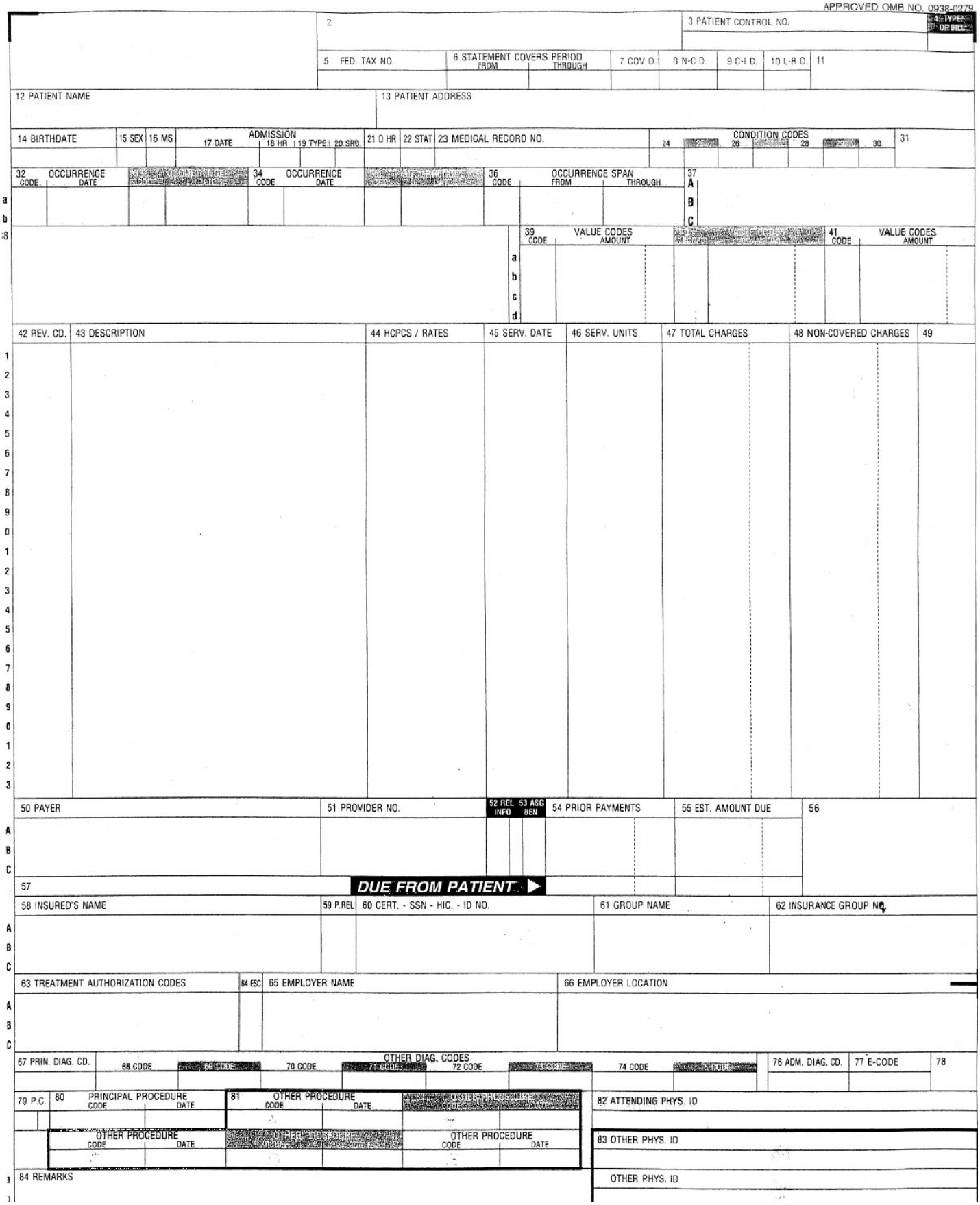
| 68.**-<br>75.** | Other Diagnosis Codes | Enter any additional ICD-9-CM diagnosis codes for which treatment was given. |
| 76. | Admitting Diagnosis | Leave blank. |
| 77. | E-Code | Leave blank. |
| 78. | Unlabeled field | Leave blank. |
| 79. | Procedure Coding Method | Leave blank. |
| 80.** | Principal Procedure Code and Date | Enter the appropriate CPT surgical procedure code for the principle procedure. The date on which the procedure was performed **must** be shown. Only the month and day are required. |
| 81.** | Other Procedure Codes and Dates | If more than one procedure was performed, enter the appropriate CPT surgical procedure code(s) and the date the procedure(s) was (were) performed. Only the month and day are required. |
| 82.* | Attending Physician ID | Enter the attending physician's Missouri (or state) license number, Missouri Medicaid provider number, or UPIN number. |
| 83.** | Other Physician ID | If applicable, enter the admitting physician's Missouri (or other state) license number, Missouri Medicaid provider number or UPIN#.<br><br>If the patient's services are restricted due to administrative lock-in, enter the lock-in physician's number in this field and submit the Medical Referral Form of Restricted Recipient (PI-118 form). |
| 84.** | Remarks | Use this field to draw attention to attachments such as operative notes, TPL denial, etc. |
| 85. | Provider Representative | Leave blank. |
| 86. | Date | Leave blank. |

(1) NOTE: This field is for private insurance information only. If no private insurance is involved, **LEAVE IT BLANK**. If Medicare, Medicaid, employer's name or other information appears in this field, the claim will deny.


APPROVED OMB NO. 0938-0279
2
3 PATIENT CONTROL NO.
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7 COV D.
8 N-C D.
9 C-I D.
10 L-R D.
11
12 PATIENT NAME
13 PATIENT ADDRESS
14 BIRTHDATE
15 SEX
16 MS
17 DATE
ADMISSION 18 HR 19 TYPE 20 SRC
21 D HR
22 STAT
23 MEDICAL RECORD NO.
24
CONDITION CODES 26 28 30
31
32 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
36 OCCURRENCE SPAN CODE FROM THROUGH
37
39 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATES
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
50 PAYER
51 PROVIDER NO.
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56
57
DUE FROM PATIENT
58 INSURED'S NAME
59 P.REL
60 CERT. - SSN - HIC. - ID NO.
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 ESC
65 EMPLOYER NAME
66 EMPLOYER LOCATION
67 PRIN. DIAG. CD.
68 CODE
69 CODE
70 CODE
OTHER DIAG. CODES
71 CODE
72 CODE
73 CODE
74 CODE
75 CODE
76 ADM. DIAG. CD.
77 E-CODE
78
79 P.C.
80 PRINCIPAL PROCEDURE CODE DATE
81 OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
OTHER PROCEDURE CODE DATE
82 ATTENDING PHYS. ID
83 OTHER PHYS. ID
OTHER PHYS. ID
84 REMARKS